MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, October 18, 2001
10:05 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

**Agenda item:**
**Consumer coalitions in Medicare**
Susanne Seagrave, Scott Harrison

MS. SEAGRAVE: I'm here today to talk about MedPAC's mandated report on consumer coalitions in Medicare. Just to give you a framework for the progression of this report, we were going to present our findings on this in September and allow the Commission the chance to discuss the findings before we drafted the letter report. Because of the compressed time frame, we went ahead and drafted the letter that is included in your meeting materials. That letter, with the attached Mathematica summary of the expert panel meeting that we had this summer, are intended to satisfy the mandate. We hope to be able to finish those up at this meeting. We would like to get the Commission's feedback on both of those things.

This study is mandated by the Benefits Improvement and Protection Act of 2000. BIPA required MedPAC to make a recommendation concerning the potential of consumer coalitions for Medicare and the merit of conducting demonstrations to test their feasibility. This mandated report is due to the Congress by December 21st of this year.

I'd like to begin by outlining the concept of consumer coalitions in Medicare. According to the proponents of the idea, coalitions provide localized information on fee-for-service Medicare and other Medicare options, including Medicare+Choice, Medigap, possibly long-term care insurance, and prescription drug coverage.

Proponents also envision coalitions acting as purchasing agents, negotiating with insurance companies for better benefits or lower premiums on behalf of their beneficiary members.

The proponents envision a structure in which individual Medicare beneficiaries would have the option of joining coalitions which would be run by community-based non-profit organizations with oversight from a board composed largely of Medicare beneficiaries. Beneficiary participation in these coalitions would be strictly voluntary. Meaning, for example, that an individual beneficiary member could decide, after the coalition completed its negotiations, whether or not to sign up with the plans or insurers that the coalition completed its negotiations with.

The coalitions would also receive direct federal funding.

To study the question posed by Congress, MedPAC staff analyzed the findings of an expert panel meeting which Mathematica convened for us in July under contract with us, to discuss the potential for consumer coalitions in Medicare. We also interviewed the advocates of the consumer coalitions idea, spoke with CMS representatives, and did a site visit to the D.C. SHIP.

The D.C. SHIP is representative of many of the SHIPs nationwide, has some similarities, some differences, but it conducts telephone and face-to-face sessions and other types of things that the SHIP network nationwide provides.

From this analysis, MedPAC finds that coalitions would

likely not add value beyond what the SHIPs could do with additional funding, and could add another layer of confusion to an already complex system for delivering beneficiary information. Non-profit organizations can already participate within the SHIP system to disseminate beneficiary information, but if they were to receive separate direct federal funding would introduce another competitor for limited available funding.

We find that coalitions would likely not have enough leverage to negotiate effectively with insurers in local markets because they would bring relatively small membership populations to the negotiating table. And the voluntary nature of the member participation would mean that the membership population the coalition did bring to the table would be highly uncertain, since beneficiaries could decide not to sign up with the insurer even after the negotiations were completed.

Finally, the coalitions could potentially face adverse selection problems. In addition, the non-profit organizations that would run the coalitions likely lack the necessary expertise to negotiate effectively with insurers.

In view of the potential for coalitions to cause confusion and their limited potential for success, we recommend that the Secretary not conduct demonstrations of Medicare consumer coalitions.

MR. DEBUSK: I agree.

DR. WAKEFIELD: The document that you gave us to read in advance certainly takes the reader, I think, right to that conclusion. There's not much in the way of pros that are listed, in terms of supporting an alternative to what you've recommended.

Though I was interested with the footnote on page two of the document you provided us. It says the panel that Mathematica convened reached a consensus across the groups that were represented at the table. And I was really interested, and we just got that today, who was on that panel. Because I was kind of surprised, it's so rare you see consensus around anything. This would be one such thing. So I was kind of surprised that this was such a slam dunk, taking us to the recommendation.

So for example, you've got the National Council of Aging, we just got this one-page document today, too, which seems to be a dissenting voice, and yet they were on the expert panel.

So I'm wondering, was this really a consensus or was there a different view?

DR. REISCHAUER: Just like the one we had on rural issues.

[Laughter.]

DR. WAKEFIELD: You guys made the mistake of expressing a different view after the fact then, Bob. Sort of a private conversation, for the rest of you. So there's my question.

Maybe we ought to be just a little bit cautious in terms of what we're submitting. I think the convening of that panel was really important. But if there was some other opinion expressed, maybe we ought to soften that language just a bit.

DR. ROSS: As one who was in the room for that meeting, if you don't like consensus, it wasn't unanimity, but overwhelming majority.

DR. WAKEFIELD: That would be fine.

MR. FEEZOR: Just as a disclaimer, when I was a regulator about 15 or 18 years ago we brought up one of the first SHIPs and then lobbied to get some federal grant money, which became institutionalized. I need to do that, though I haven't talked to those folks in about seven or eight years.

I think it is important, and Susanne, like Pete, I agree pretty much with the conclusions. I think maybe there is two things that bear pointing out.

One is, correct me if I'm wrong, none of the SHIPs do collective negotiation with insurers. They're more fact and disclosure. So we need to make that as one significant difference that I think the people who suggested different consumer coalitions be formed, that SHIPs were never intended to do and, to my knowledge, do not anywhere in the country.

Second, and I think the SHIP programs do extraordinary work. The one in California does excellent work, as well as the one in my native state of North Carolina. I guess I wonder, though, if it might be appropriate that the Secretary or appropriate entity try to get some measure on the effectiveness of those entities.

I guess my question would be probably not all of them are equally effective and there may be some states that, in fact, do not have benefit of effective or strong SHIPs. And it may be that some consideration may be given to trying to spark or regenerate effective information counseling services in those states where that is not present, as one of the actions that might be taken short of funding new coalitions.

DR. REISCHAUER: From the information you gave us, Susanne, it seems an unambiguously bad idea. So I was wondering how it even got this far?

I was wondering, if I understood this correctly, when we're talking about these organizations as negotiating bodies, you become a member of one of these organizations and they negotiate with Aetna. And then Aetna offers a plan that is only available to those people who are in the group? Or is the group open so anyone can then subsequently join? And is there then, as you said, a small fee maybe of $10 to join? Which is a hurdle to get what, in the rest of Medicare, is basically open entry.

It just struck me as something that went against the grain of Medicare as a universal entitlement program.

MS. SEAGRAVE: Just to answer a question really quickly, what the proponents are proposing is to actually run demonstrations of different models. So they're not proposing one specific model. So it's not clear exactly would -- it's not clear how they would work with the insurers, whether they'd work with just one insurer, or multiple insurers. They're proposing to test different models, in a sense.

So everything that you mentioned could potentially be in one or another model that they're proposing.

MR. HACKBARTH: All other things being equal, I love the idea of demonstrating new ideas. What holds me back in this case and some others is that the potential topics for demonstration far outnumber the resources available to do it. So I think we need to be cautious about adding still more to the list.

I want to focus on the purchasing coalition piece because

for me there are some disconnects, just based on my own personal experience in dealing with people like Allen Feezor around negotiations. Employers are effective in negotiating with health plans to the extent that they are empowered to make decisions, steer people to particular contractors, take away options. That's what gives them their leverage.

The question that this raised for me is the extent to which these sorts of relatively loose affiliations of people, voluntary associations, will be able to actively, aggressively, direct populations -- enough of a population to a health plan to be able to get anything for it. If you can only steer a few people and they're of unknown risk, you've got an inherently weak negotiating position. If you can steer a lot of people with a reasonable assurance of a variety of risk, or a relatively normal selection of risk, you can drive a pretty hard bargain.

I don't see how you get to that hard bargain situation with these voluntary groups. That's the question I keep coming back to.

You're shaking your head, that sounds similar to what you heard in the expert panel?

MS. SEAGRAVE: Yes, definitely. In my discussion I said that, first of all, the feeling is that these coalitions memberships would be very small, that they would be highly uncertain, and that they could even potentially have some adverse risk selection problems. So they would have difficulty getting that leverage in the market for those reasons, and possibly for other reasons, as well.

DR. REISCHAUER: But just at this moment in our history, we hear from Jack and Janet that many of these plans are teetering on the edge. There's not a lot of let's say fat or rent to be extracted from them anyway. Why would we want to move forward with a demonstration to see whether a weak body could extract fat from a thin person.

MR. HACKBARTH: That's a nice summary.

MR. SMITH: I, predictably, would express some reservations about assuming that any voluntary group of folks who want to bargain are weak. But it does seem to me it ought to be a voluntary group of folks who want to bargain, not a group of folks created by the Secretary through a demonstration.

But more importantly, trying to follow Allen's point, the summary documents suggest that while some SHIPs may be doing terrific work, that knowledge of the program is uneven and, on balance, inadequate. It does seem to me that we might want to pick up on that finding and ask ourselves whether or not something the Secretary ought to do -- either best practices work, disseminating lessons from the better SHIPs, perhaps reconsidering possibilities of additional funding that tries to improve beneficiaries' understanding of the program and access and ability to manipulate.

I'm not sure that consumer coalitions are the answer. And if they are, I'm not sure the Secretary should pay for them. But it doesn't seem to me we ought to ignore the evidence that suggests that information is inadequate and think about ways to improve it.

MR. HACKBARTH: Other comments or questions?

MS. NEWPORT: Our experience with the SHIPs, in terms of access and information for beneficiaries, has been very positive. Much to their chagrin I told that to them, and they're not quite sure what to make of that. And it is true, and I think we look to them sometimes as a valuable partner in getting information out.

But there are various skill sets out there amongst the states, and California is particular good, by the way. I agree with Allen.

I just think that when I look at the notion that they can negotiate better drug prices for beneficiaries, help with that, a little bit of a reach. We're having, with a million members in our program, a continuing challenge in doing that and we actually do very well at it.

But I really do agree with the rest of the Commission, in the need for the right kind of information, well thought out, well delivered, has always been a challenge. And we should support and continue to support that.

I agree with the recommendation. I think we just need to make sure the information is the right scale.

MR. HACKBARTH: I think the question that we're faced with is not whether these are good ideas or bad ideas, or whether maybe they would work in some local circumstances or not. Rather, the question is is the level of promise sufficient that we would recommend that very scarce resources of demonstration dollars be applied to this topic.

I just want to be clear, from my perspective this is not about condemning these ideas, or even saying they can't work. They won't work under some circumstance, but we're rationing a scarce resource here and the recommendation on the table is that in that context, in view of these scarce resources, this isn't a sufficiently high priority that we ought to recommend or require demonstrations.

I think if we can dispose of this today it would be a good thing to do. Are people ready to vote on that?

MR. FURMAN: If the committee is going to make a decision, I'm the author of this report. I would request the opportunity to talk for two to three minutes.

MR. HACKBARTH: Okay.

MR. FURMAN: Thank you. My name is Jim Furman. I'm the President of the National Council on the Aging and the founder of the United Seniors' Health Cooperative, a consumer information coalition founded by Dr. Fleming and Esther Peterson.

The impetus for this study, for this whole effort, was a feasibility study funded by the Retirement Research Foundation with four authors: myself; Dave Kendall from the Progressive Policy Institute; Jay Greenberg who is the founder of social HMOs and also the CalPERS Quantum Care product; and Dwight McNeil who is an expert in employer purchasing programs.

Involved is an eminent expert panel of people, Stuart Butler, John Rother and a variety of other people, who are also part of the recommendations for this report.

I would at least request -- I'm a bit troubled by the fact

that that report -- I'm not aware whether that report has been made available to the members of this committee as well, presenting and I think answering many of these points of views.

I would like to clarify a few points. First of all, we're proposing two separate types of organizations, an information coalition demonstration and purchasing coalition demonstration. Let me speak to the specific concerns that were raised about both of them.

The concern was that the information coalition, there would not be any value added, other than funding the SHIP program. The current reality of SHIP program, for anybody who's involved on the ground level, I'm not aware of any program that reaches more than 2 or 3 percent of the beneficiaries in their state. In fact, most of the delivery of services is by volunteers who have probably had six or eight hours of training, and therefore are quite limited in their ability to provide substantial information.

The comment was made, for example, in Washington D.C. we visited the SHIP program. In addition to the SHIP program in Washington, D.C., there's the United Seniors' Health Cooperative, there's AARP, there's employers, there are all groups. What we have now is tremendous duplication. We have six or eight groups, all producing your basic one-on-one guide to Medicare and not much more sophistication beyond that.

The specific recommendation was to create a different paradigm and a public/private partnership for the delivery of education and counseling information that would leverage all of the resources of employers, of union, of AARP chapters, of other groups to provide that information and to also reduce what is now tremendous duplication and lack of reach.

In addition, private groups have the ability to say what needs to be said. I, by the way, was a strong proponent of the SHIP program. But if you go to a SHIP program and said what about American Integrity Insurance, Provider Fidelity Insurance, United American, companies which have terrible reputations, the answer you will get is they are licensed to be sold in the state. State entities can sometimes not tell you what you need to know about insurance to be informed consumers.

The fundamental point of this is public/private partnerships, coalitions and coordinated resources can stretch whatever dollars are available much more significantly.

The second type of demonstration that's proposed is purchasing coalition. The essential element of this is to take what has worked in the under-65 market, group purchasing, group negotiation, and apply that to the Medicare market. To say that it can't be done is disingenuous. I point, for example, to the Minnesota Senior Federation with 30,000-plus members which has, in fact, already negotiated with networks and doctors and hospitals to accept assignment for all Medicare beneficiaries within 200 percent of the poverty level and also could easily get the waiver of copayments and deductibles. To say it can't be done is to ignore the facts.

The San Francisco Business Group on Health, which I think anybody would agree is a sophisticated purchasing entity, has

wanted to do this for years. They are able to negotiate benefits for their under-65 market. They have the clout right now. They do not now have the ability to do that. To say that employers, AARP, unions, and other groups do not have the sophistication to do this, I think ignores the facts.

Now you can argue that there's a chance that this won't work. Clearly, some people are threatened by the fact that it might work and obviously some smart people think it can work. I think there's a tremendous cost -- there's a slight cost to doing the demonstration, we spend the money and it doesn't work. I think there's a major cost to not doing the demonstrations. We will not having any advance in knowledge and we'll be having the same discussion and the same debates five years from now.

So thank you for that. We had about one hour of conversation in this whole process with the MedPAC staff. I would really urge that the members of this commission read the report that was the basis of the Congressional mandate. Thank you.

MR. HACKBARTH: Thank you. We're not going to take further public comments at this point.

MR. ZESK: I was one of the people who was there at this meeting on the 17th, and it was not the same meeting that was characterized here today.

MR. HACKBARTH: Let me just say a word about the process here. Pardon me, as a rookie chairman, for being maybe a little bit uncertain about some of these procedural issues.

The nature of this commission is that we could never get our work done if, on every topic before us we had expensive public hearings. The amount of resources that we have, both staff resources and commissioner time, are such that we cannot proceed in that way. We would not be able to serve the interests of the Congress. We wouldn't be able to meet their requests.

So inevitably, we depend on the staff, an excellent staff in my judgment, to collect information, hold expert panels, in a variety of ways bring information to us and digest it for us. So we can't establish the precedent that we can't make a decision until we hear everybody in a room on each topic. I actually regret even cracking that door just a bit a few minutes ago.

On this particular question now, moving from the general procedural point, we did get some materials this morning that at least I hadn't seen at this point. Two, as I recall. One from the National Council and then another that I'm not sure of the source. Oh, this is the summary, so it's just one additional document.

If members of the commission feel like they don't want to proceed to a decision at this point, we can take up a vote tomorrow. They can look at the documents that we got today and revisit the question. Is that how people would like to proceed? Jack?

DR. ROWE: There's a list here of the expert panel that the staff brought together. I have a few questions about it. One is I note that one of the members of it is a representative of the National Council on Aging, Howard Bedlan, or is listed as such.

The second is it's a little hard, from looking at this

expert panel report, to get a sense of whether this was a 90/10 view or 55/45 view, in terms of where they came out with respect to the MCCs. It would be helpful to hear a little more about that.

Because the pros and cons are all listed here very nicely, but I don't get the sense of how the discussion was.

DR. ROSS: Jack, that was my mysterious reference earlier to Mary's point about consensus. 90/10 is a characterization. And I'll be candid, I was quite surprised going in. Given the diversity of the members of the panel, I would have predicted something much more even or -- that's overwhelming.

DR. ROWE: Fine. That's very helpful.

MR. HACKBARTH: So let's do this. People should look at the document that we received this morning. Then we will take this up tomorrow for a final decision.

**Continuation of discussion, October 19**

MR. HACKBARTH: Consumer coalitions. Susanne?

MS. SEAGRAVE: I just wanted to remind everyone that we had discussed yesterday the potential for consumer coalitions on the information side to cause confusion, and their limited potential for success in the purchasing side. Based on those two things we recommend that the Secretary not conduct demonstrations of Medicare consumer coalitions.

MR. HACKBARTH: I'd like to offer a proposal. Not on the recommendation, per se, but on the context of what we say in the letter itself, the preamble, if you will, to the recommendation. I'd like to see a few points made. One, that it's the sense of the Commission that getting appropriate useful information to Medicare beneficiaries is a very important issue. It's a very serious problem as things now stand. Notwithstanding that though, it is -- actually let me hold off on that because it really pertains to the recommendation.

Second, again to put this recommendation in context, is that we were asked a narrow question about whether this should be a top priority as a demonstration. So from my vantage point, we are not passing on the merits of these coalitions, whether it be the information coalition or the purchasing coalition, per se. The question that we're addressing is actually whether they are at the top of the list for very scarce Medicare demonstration dollars.

So to me those are two important points of context that ought to be emphasized.

Now let's turn to the draft recommendation. Is there any further discussion of this that people want to have?

MR. FEEZOR: Glenn, just on your context, if you will. I think also it might be nice to complement the importance of Medicare eligible education, to recognize that in fact there is federal effort or support and that it might be improved, or the Secretary might in fact look to make sure that the existing educational effort in fact leverages as much of local resources and activities that it might, and some of the concepts that were presented by some of the speakers on that.

But anyway, just basically I guess in essence that the Secretary might make sure that, whether it's the sharing of best practices, which my recollection is they do do in their meetings, and the SHIP programs. But the importance of that and making sure that that's constantly being reinvigorated or improved, looked to improve, would be also encouraged.

MR. SMITH: Glenn, briefly, I think the recommendation ought to be modified to incorporate the notion that given the scarcity of Medicare demonstration resources, funding consumer coalitions should not -- rather than this. As drafted it's inconsistent with your notion that context ought to establish, there may be something good to do here. We should simply say, we shouldn't spend money on it now because it doesn't jump to the top of the queue. I would agree with Allen's modification of the context stuff, and if Sheila were here she would, I think, also agree

with Allen and with you, and she wanted to be on record. Since she can't vote, I just put her on record.

DR. ROSS: Perhaps in November when we go to Powerpoint this would be much easier to do, but for the moment we're pencil and paper. To take your suggestion that would be revised to read then, given the scarcity of resources -- we may find a slightly different way of phrasing that thought -- the Secretary should not give priority to demonstrations of Medicare consumer coalitions, as opposed to should not fund?

MR. SMITH: I would even say, should not support or should not fund. But I think we ought to set it in the scarcity context, sort of the relative value.

DR. ROSS: Okay, given scarcity of resources for demonstrations, the Secretary should not fund demonstrations of Medicare consumer coalitions.

MR. HACKBARTH: Let me offer one other point that maybe goes in the first part, the context. One of the questions that I have about this as a high priority use of demonstration dollars is whether this is even the sort of thing that is amenable to demonstration. The nature of these activities, in my view and my experience, is that they are very dependent on the people involved, the local market dynamics, and the like. You could do a demonstration in Rhode Island and know very little about whether the mechanism would work in San Jose or some other part of the country.

When we use our demonstration dollars, limited as they are, we ought to be trying to learn things of broad applicability, and I don't think this passes that test.

DR. REISCHAUER: I think that's true of almost everything and that's why when you do a demonstration you might do it in eight sites that differ, to get some feel for how something would play out nationally.

DR. ROSS: As distinct from a payment system?

MR. HACKBARTH: Payment systems, for example, I think are less dependent on the local personal dynamics and institutional structures.

DR. REISCHAUER: No, absolutely. I'm not saying that that isn't the case. But does that mean you rule out demonstrations on anything that has a human or a local --

MR. HACKBARTH: You're right in saying we need to be --

DR. REISCHAUER: That we shouldn't do it? We have the Medicaid program which is different in every state, and yet we run demonstrations all the time.

MR. HACKBARTH: I won't insist on inclusion of this point if there is significant disagreement about it. But to me it goes to the issue of priority. That in fact when you have very limited resources I think that this is not something that you use to rule out forever a type of demonstration, but it certainly deserves weight in considering what priority you give to things. That was my only point.

DR. REISCHAUER: I would hope we would use the word resources rather than dollars. You've been switching back and forth. Because from my perspective, the limited resource is really management and administrative capability at CMS with

everything else they have on their plate.

MR. HACKBARTH: Your point is well taken.

DR. REISCHAUER: In terms of dollars, this is a trivial amount of money.

MR. HACKBARTH: I agree, Bob. Any further discussion?

So the vote is on the draft recommendation as amended by Murray. Do people need to hear that again?

All opposed to the draft recommendation as amended?

All in favor?

Abstaining?

Thank you.